Home Health Certification and Plan of Care

Order ID: 1150/17880

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
36883744	04/04/2026	From: 04/04/2026 To: 06/02/2026	24172	217058

6. Patient's Name and Address

Joyce Campbell
2810 Ruscombe Lane,
BALTIMORE, MD 21215-
347-578-0127

7. Provider's Name, Address and Telephone Number

HomeCentris Healthcare LLC
10 Crossroads Drive, Suite 102
Owings Mills, MD 21117-8284
410-321-8448
1487113239

8. DOB 09/30/1935 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
L89.153	Pressure ulcer of sacral region stage 3	04/04/26

13. ICD	Other Pertinent Diagnoses	Date
M06.9	Rheumatoid arthritis unspecified	04/04/26
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	04/04/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	04/04/26
N18.4	Chronic kidney disease stage 4 (severe)	04/04/26
D63.1	Anemia in chronic kidney disease	04/04/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	04/04/26
M10.9	Gout unspecified	04/04/26
F41.9	Anxiety disorder unspecified	04/04/26
F32.9	Major depressive disorder single episode unspecified	04/04/26
D47.2	Monoclonal gammopathy	04/04/26
K21.9	Gastro-esophageal reflux disease without esophagitis	04/04/26
E07.9	Disorder of thyroid unspecified	04/04/26
M19.90	Unspecified osteoarthritis unspecified site	04/04/26
E11.69	Type 2 diabetes mellitus with other specified complication	04/04/26
E78.5	Hyperlipidemia unspecified	04/04/26
E66.3	Overweight	04/04/26
Z68.29	Body mass index [BMI] 29.0-29.9 adult	04/04/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	04/04/26
Z79.51	Long term (current) use of inhaled steroids	04/04/26
Z79.01	Long term (current) use of anticoagulants	04/04/26

10. Medications: Dose/Frequency/Route (N)ew (C)hanged

TYLENOL 500 mg/tablet / Take 2 tablets by mouth every 8 (eight) hours as needed for pain Do not exceed 3000 mg per day
Ventolin Hfa - Albuterol Sulfate 90 mcg/actuation inhaler / Inhale 2 puffs inhalant every 6 hours as needed for wheezing
ELIQUIS 2.5 mg / 1 Tablet by mouth 2 (two) times a day
DULCOLAX EC 5 mg / 1 Tablet by mouth daily as needed for constipation
Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1000 Unit / 1 Tablet by mouth daily
FLONASE 50 mcg/actuation nasal spray / 2 sprays by each nare Nasal once a day
LASIX 20 mg / 1 Tablet by mouth daily
Xyzal - Levocetirizine Dihydrochloride 5 mg / 1 Tablet by mouth once a day IN THE EVENING
menthol-zinc oxide (CALMOSEPTINE) 0.44-20.6% ointment / Apply 1 application topically as necessary for irrigation
GLUCOPHAGE 500 mg / 1 Tablet by mouth 2 (two) times a day with meals
TOPROL-XL 25 MG 24 hr tablet / 1 Tablet by mouth once
REMERON 30 mg / 1 Tablet by mouth nightly
SINGULAIR 10 mg / 1 Tablet by mouth nightly
ROXICODONE Immediate Release 5 MG / 1 Tablet by mouth every 6 (six) hours as needed for severe pain Max Daily Amount: 20 mg
MIRALAX 17 gram packet / Take 17 g by mouth daily
CRESTOR 10 mg / 1 Tablet by mouth daily
ULTRAM 50 mg / 1 Tablet by mouth every 12 (twelve) hours Take 1 tablet (50 mg) in the morning and evening every 12 hours
KENALOG 0.1% ointment topically twice a day

14. DME and Supplies:

wheelchair, hoyer lift, , hospital bed

15. Safety Measures:

standard precautions, fall precautions, bleeding precautions, bedrails up while in bed

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

azithromycin ceftriaxone

18.A. Functional Limitations

Ambulation, Bowel/Bladder Incontinence

18.B. Activities Permitted

Wheelchair, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 0. Never, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes

20. Prognosis: fair

22. A Rehabilitation Potential:

SELF-CARE: 1. Dependent - A helper completed all the activities for the patient., MOBILITY: 1. Dependent - A helper completed all the activities for the patient.

22.B.Discharge Plans

patient will be responsible for managing treatment
family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Pressure ulcer of sacral region stage 3, the patient is experiencing decreased endurance and mobility, increasing the likelihood of falls. To safely leave their home, the patient needs assistance from another person and an assistive mobility device.

Clinical Condition Requiring Homecare:

The patient is a 90-year-old female referred to home health services for evaluation and management of a sacral wound and generalized weakness. Her past medical history is significant for rheumatoid arthritis, type 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-12 CE-FMS-diabetes">diabetes</mh> mellitus, <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-6 CE-FMS-hypertension">hypertension</mh>, and chronic kidney disease. The patient was seen for the start of care (SOC) visit and was noted to be alert and oriented to person and place, and intermittently to time (A&O x2-3), with occasional forgetfulness. The patient is chairfast and has been largely bedbound for several years secondary to advanced rheumatoid arthritis and severe functional limitations. She is unable to propel herself in a wheelchair and requires total assistance for all activities of daily living, including dressing, bathing, and mobility. The patient has a live-in caregiver who provides 24-hour care, and her daughter also assists periodically with caregiving needs. Assessment revealed a Stage 2 pressure injury located on the posterior upper leg beneath the buttock measuring approximately 7.5 cm x 4 cm, as well as a Stage 2 pressure injury at the coccyx measuring approximately 1 cm x 1 cm. The patient reports right leg pain and chronic generalized arthritic pain, typically ranging from 5/10 to 8/10 in intensity, which is currently managed with a prescribed pain regimen and reported to be adequately controlled at this time. The patient requires a Hoyer lift for all transfers and is completely dependent for bed mobility and repositioning. According to the caregiver, the patient spends most of her time in bed but is transferred via Hoyer lift to a wheelchair or lounge chair in the living room approximately two to three times per week. The patient has not ambulated or stood for several years. When leaving the home for medical appointments, she requires wheelchair transport and full caregiver assistance, meeting criteria for homebound status due to severe mobility limitations, dependence on assistive equipment, and the need for human assistance for safe mobility outside the home. The patient demonstrates significant functional deficits including decreased bilateral lower extremity strength, impaired functional mobility, inability to perform independent transfers, chronic arthritic and wound-related pain, decreased balance, decreased safety awareness, and increased risk for falls and further functional decline. Skilled physical therapy services are indicated to address strengthening, bed mobility, safe transfer techniques utilizing the Hoyer lift, positioning strategies, and pressure ulcer prevention in order to maximize safety and prevent further decline. The patient was instructed on positional strategies to reduce the risk of developing additional pressure injuries and to prevent progression of existing wounds, including frequent repositioning at least hourly, side-lying positioning when in bed, avoiding prolonged elevation of the head and foot of the

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 04/04/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Arveitta Edge
6701 N Charles St
Towson, MD 21204
PHONE: 14438492397 FAX: 14438492398 NPI: 1356693048

26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.

F2F date : 03/24/2026

27. Attending Physician's Signature and Date Signed **05/05/2026**: Date of physician last face-to-face

28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

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hospital bed when possible, and transferring out of bed into a wheelchair when tolerated. Education was also provided regarding pressure ulcer prevention, common pressure points, and monitoring for early signs of skin breakdown. Additional education was provided to the patient and caregiver regarding edema management, including the importance of elevating the lower extremities above heart level during rest periods and the potential use of compression garments if recommended by the physician. The patient and caregiver were instructed on signs and symptoms of wound infection, including fever, chills, redness, swelling, increased pain, bleeding, drainage, nausea, vomiting, or worsening symptoms not relieved with medication. Home safety education and fall prevention strategies were also reviewed, including environmental safety measures to reduce fall risk. Therapeutic exercises were initiated in a seated position, including hip flexion, long arc quadriceps, hip abduction, and pillow squeeze exercises, with a written home exercise program left in the home and instructions to perform exercises twice daily as tolerated. Pain management education was reinforced, including taking pain medication at the onset of pain, monitoring for potential side effects such as dizziness and constipation, and seeking emergency medical attention or contacting the provider for symptoms such as chest pain, uncontrolled pain, or shortness of breath. The patient was also advised to take pain medication approximately one hour prior to physical therapy sessions to improve tolerance to activity. The patient and caregiver demonstrated understanding of the education provided through teach-back. Occupational therapy evaluation indicates the patient remains dependent for dressing, bathing, and most self-care tasks, with the caregiver reporting increased difficulty assisting with bed mobility and ADLs over the past several months. Skilled occupational therapy services are recommended to address ADL training, therapeutic exercise, development of a home exercise program, functional sitting balance, and caregiver training to improve safety and care management. Physical therapy services are planned at a frequency of one visit per week for six weeks beginning 04/10/2026 to address strengthening, mobility training, positioning, and pressure relief strategies. Without skilled therapy intervention, the patient remains at significant risk for further functional decline, worsening pressure injuries, and increased caregiver burden. The patient and caregiver are in agreement with the established plan of care.
 Date of Order 04/04/2026 Orders Physician Face-to-Face Date: 03/24/2026 Clinical Condition Requiring Home Care per Certifying Physician: Home Care for Wound - Home Health aide, PT, OT due to Pressure ulcer of sacral region stage 3 Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home
 1 - SOC - SN Notes: soc PT Eval Notes: OT Eval Notes: Physician Edge, Arveitta

SN Careplans

SN WK1: 1 (04/04/26-04/04/26) ,WK2: 1 (04/05/26-04/11/26) ,WK3: 1 (04/12/26-04/18/26) ,WK4: 1 (04/19/26-04/25/26) ,WK5: 1 (04/26/26-05/02/26)

PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 95 > 100, heart rate < 50 > 110, respiratory rate < 8 > 22, blood pressure systolic < 90 > 169, blood pressure diastolic < 60 > 90, O2 saturation < 88 > 100, pain < 0 > 5

CAREGIVER: 1. Non-agency caregiver(s) currently provide assistance

HOSPITALIZATION RISKS: 7. Currently taking 5 or more medications

STANDING ORDERS: infection control: hygiene, proper hand washing; advance directive: plan if patient is unable to make healthcare decisions ; fall precautions: wear sensible shoes, remove home hazards, living space adequately lit, assistive devices prn; emergency preparedness: plan for prn evacuation, resumption of home health visits; Assess the patient's incision on post op day 7 and the nurse or physical therapist will remove aquacel dressing leaving OTA; if incision is draining educate pt/pcg on cleaning with normal saline and covering with dry gauze daily and as needed.
Assess/Instruct Pt/Pcg: Ice to ____ x 20 minutes each hour while awake. If cold machine ordered apply 20 minutes on and 20 minutes off for 3-4 times a day.
Assess/Instruct all body systems/vital signs/complications, Blood Pressure; systolic is greater than 169 mm Hg or less than 90 mm Hg; diastolic is greater than 100 mm Hg or less than 55 mm Hg, Clinician to assess comorbidities and report changes in condition to the patient's physician, Pain Rating is greater than 6 on 0-10 scale, Pulse is greater than 110 or less than 50, Respirations are greater than 22 or less than 8, SPO2: is less than 90 % at rest /with exertion, Temperature is greater than 100.5 F or less than 95.0 F, Pain Rating is greater than 6 on 0-10 scale
Implement Fall Prevention Program, Instruct and educate the patient/PCG on wearing compression stockings for the next 4 weeks per discharge instructions.
Instruct the pt/PCG on using the incentive spirometer 10 times every 2 hour while awake.
Provide education content at patient's level of health literacy.
Assess/Instruct Pt/Pcg: Safety measures to prevent injury.
Assess: Musculoskeletal status.
Teach Pt/Pcg to maintain appropriate wt bearing status as ordered by MD, total joint replacement precautions as applicable, Safe stair climbing skills, Safe, effective use of adaptive/assist device
Assess/Instruct Pt/Pcg: Pain management measures; assess pain level, pain medication, rest, body alignment, ROM, meditation, massage.
Pt/Pcg educated in pain management techniques including positioning and relaxation techniques
Instruct Pt/Pcg: Medication actions, uses, frequency, dose, side effects, interactions of all new/change meds, Provide medication education,.
Assess/Instruct Pt/Pcg: Safety measures to prevent injury, Therapeutic Exercise, Transfer Training
Monitor surgical wound for s/s of infection, educate on s/s of concern and infection prevention to promote wound healing.

; Skin Preservation: Measures to prevent skin breakdown; pressure relief, incontinence care, nutrition, hydration ; Pain: Pain management measures; pain medication, rest, body alignment, ROM, meditation, massage ; Medications: Medication actions, uses, frequency, dose, interactions of all new/change meds
Advance Directive:None

PROBLEMS IDENTIFIED ON ASSESSMENT: M1700 - Cognition, D0160 - Depression, M2020 - Oral Med Management, meal preparation, M1400 - Dyspnea, limited strength, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, B1000 - Vision Deficit, open sores/lesions, #1 - 2 - Partial thickness loss of dermis presenting as a shallow open ulcer with red

SN Goals

PATIENT-STATED GOAL: I want to be without pain and weakness;

GOALS
patient/caregiver recalls
* lifestyle modifications to manage respiratory condition including
* diet changes and regular exercise
* strategies to control shortness of breath
* home remedies to keep lungs healthy
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to achieve wound healing including cleaning and dressing wound
* position changes
* skin care
* diet modification
* record wound measurements
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain
* teach relaxation skills and diversional activities
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to keep home safe for patient with dementia
* coping strategies for the caregiver* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* depression-prevention strategies including avoidance of isolation
* healthy eating
* sleeping habits
* identification of activities that bring pleasure
* preventive care
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

patient self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

meal preparation is available to patient for all meals

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
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lesions, #1 - 2 - Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed. - Posterior Left Thigh - , #2 - 2 - Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed. - Posterior Left Buttock -

PROCEDURES: physician-ordered wound care: #2 - 2 - Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed. - Posterior Left Buttock -, physician-ordered wound care: #1 - 2 - Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed. - Posterior Left Thigh -, cough/deep breathing exercises, incentive spirometer, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, physician-ordered wound care, wound vacuum, coordinate/arrange preparation of missing meals, coordinate/arrange resources for vision-impaired

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage respiratory condition including diet changes and regular exercise strategies to control shortness of breath home remedies to keep lungs healthy, related medication(s) purpose, schedule, * how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain teach relaxation skills and diversional activities, related medication(s) purpose, schedule, * how to keep home safe for patient with dementia coping strategies for the caregiver*, related medication(s) purpose, schedule, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpose, schedule, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, patient self-administers medications as prescribed, related medication(s) purpose, schedule, meal preparation is available to patient for all meals

PT Careplans

PT WK2: 1 (04/05/26-04/11/26) ,WK3: 1 (04/12/26-04/18/26) ,WK4: 1 (04/19/26-04/25/26) ,WK5: 1 (04/26/26-05/02/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, GG0170A1 - Roll left & Right, GG0170F1 - Toilet Transfer, GG0170A1 - Roll left & Right, GG0170B1 - Sit to Lying, GG0170C1 - Lying to sitting/bed, GG0170R1 - Wheel 50 ft w 2 Turns, GG0170S1 - Wheel 150 feet

PROCEDURES: train caregiver(s) to perform medical/rehabilitation treatments: Administration of HEP, wheelchair training, home exercise program: Supine- ankle pump, quad set, gluteal set, heel slide, SLR, bridging., equipment training: Use of Hoyer lift., transfers training: Ensure safety with Hoyer lift transfers, assist with infection control: Instruct Pt/PCG insigns and symptoms of infection of incision/wound, including fever, chills, redness, swelling, pain, bleeding, or any discharge from the surgical or wound site. When to notify EMS-Nausea or vomiting that does not get better, or pain that does not get better with medication.

TEACH PATIENT/CAREGIVER: * how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain teach relaxation skills and diversional activities, related medication(s) purpose, schedule, Roll left & Right - 06. Independent, Sit to Lying - 06. Independent, Lying to sitting/bed - 06. Independent, Toilet Transfer - 01. Dependent, Wheel 50 ft w 2 Turns - 01. Dependent, Wheel 150 feet - 01. Dependent

PT Goals

PATIENT-STATED GOAL: I would like to be able to stand on my feet

GOALS
Roll left & Right - 06. Independent

patient/caregiver recalls
* how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain
* teach relaxation skills and diversional activities
* recalls related medication(s) purpose, schedule

Sit to Lying - 06. Independent

Lying to sitting/bed - 06. Independent

Toilet Transfer - 01. Dependent

Wheel 50 ft w 2 Turns - 01. Dependent

Wheel 150 feet - 01. Dependent

OT Careplans

OT WK1: 6 (04/04/26-04/04/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, M1400, GG0130F1 - Upper Body Dressing, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130A1 - Eating

PROCEDURES: train caregiver(s) to perform medical/rehabilitation treatments: As needed, therapeutic exercises: As needed, equipment training, static standing balance exercises: As needed

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage respiratory condition including diet changes and regular exercise strategies to control shortness of breath home remedies to keep lungs healthy, related medication(s) purpose, schedule, * how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain teach relaxation skills and diversional activities, related medication(s) purpose, schedule, Toileting Hygiene - 01. Dependent, Shower/Bathe Self - 02. Substantial/maximal assistance, Upper Body Dressing - 03. Partial/moderate assistance, Lower Body Dressing - 01. Dependent, Don/Doff Footwear - 01. Dependent, Eating - 05. Setup or clean-up assistance

OT Goals

PATIENT-STATED GOAL: To have less pain

GOALS
patient/caregiver recalls
* lifestyle modifications to manage respiratory condition including
* diet changes and regular exercise
* strategies to control shortness of breath
* home remedies to keep lungs healthy
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain
* teach relaxation skills and diversional activities
* recalls related medication(s) purpose, schedule

Toileting Hygiene - 01. Dependent

Shower/Bathe Self - 02. Substantial/maximal assistance

Upper Body Dressing - 03. Partial/moderate assistance

Lower Body Dressing - 01. Dependent

Don/Doff Footwear - 01. Dependent

Eating - 05. Setup or clean-up assistance

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	04/04/2026

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